VIRGINIA UNIFORM ASSESSMENT INSTRUMENT

Dates: Screen ____/____/____
Assessment ____/____/____
Reassessment ____/____/____

1 IDENTIFICATION/BACKGROUND

Name & Vital Information

Client Name: _____ **Client SSN:** ___-___-____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City) (State) (Zip Code)

Phone: ( ) _____ **City/County Code:** _____ _____ _____

Directions to House:

Pets?

Demographics

Birthdate: ____/____/____ **Age:** _____ **Sex:** ___ Male 0 ___ Female 1
(Month) (Day) (Year)

Marital Status: ___ Married 0 ___ Widowed 1 ___ Separated 2 ___ Divorced 3 ___ Single 4 ___ Unknown 9

Race:
___ White 0
___ Black/African American 1
___ American Indian 2
___ Oriental/Asian 3
___ Alaskan Native 4
___ Unknown 9 _____
Ethnic Origin _____

Education:
___ Less than High School 0
___ Some High School 1
___ High School Graduate 2
___ Some College 3
___ College Graduate 4
___ Unknown 9
Specify _____

Communication of Needs:
___ Verbally, English 0
___ Verbally, Other Language 1
Specify _____
___ Sign Language/Gestures/Device 2
___ Does Not Communicate 3
Hearing Impaired? _____

Primary Caregiver/Emergency Contact/Primary Physician

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name: _____ **Relationship:** _____

Address: _____ **Phone:** (H) _____ (W) _____

Name of Primary Physician: _____ **Phone:** _____

Address: _____

Initial Contact

Who called: _____
(Name) (Relation to Client) (Phone)

Presenting Problem/Diagnosis:

CLIENT NAME: Client SSN: - -

Current Formal Services

Do you currently use any of the following types of services?

No 0	Yes 1	*Check All Services That Apply*	**Provider/Frequency:**
___	___	Adult Day Care	
___	___	Adult Protective	
___	___	Case Management	
___	___	Chore/Companion/Homemaker	
___	___	Congregate Meals/Senior Center	
___	___	Financial Management/Counseling	
___	___	Friendly Visitor/Telephone Reassurance	
___	___	Habilitation/Supported Employment	
___	___	Home Delivered Meals	
___	___	Home Health/Rehabilitation	
___	___	Home Repairs/Weatherization	
___	___	Housing	
___	___	Legal	
___	___	Mental Health (Inpatient/Outpatient)	
___	___	Mental Retardation	
___	___	Personal Care	
___	___	Respite	
___	___	Substance Abuse	
___	___	Transportation	
___	___	Vocational Rehab/Job Counseling	
___	___	Other _____	

Financial Resources

Where are you on this scale for annual (monthly) family income before taxes?

___ $20,000 or More ($1,667 or More) 0
___ $15,000 - $19,999 ($1,250 - $1,666) 1
___ $11,000 - $14,999 ($ 917 - $1,249) 2
___ $ 9,500 - $10,999 ($ 792 - $ 916) 3
___ $ 7,000 - $ 9,499 ($ 583 - $ 791) 4
___ $ 5,500 - $ 6,999 ($ 458 - $ 582) 5
___ $ 5,499 or Less ($ 457 or Less) 6
___ Unknown 9

Number in Family unit. _____

Optional. Total monthly family income _____

Do you currently receive income from . . . ?

No 0	Yes 1	*Optional Amount*
___	___	Black Lung, _____
___	___	Pension, _____
___	___	Social Security, _____
___	___	SSI/SSDI, _____
___	___	VA Benefits, _____
___	___	Wages/Salary, _____
___	___	Other, _____

Does anyone cash your check, pay your bills or manage your business?

No 0	Yes 1	*Names*
___	___	Legal Guardian, _____
___	___	Power of Attorney, _____
___	___	Representative Payee, _____
___	___	Other, _____

Do you receive any benefits or entitlements?

No 0	Yes 1	
___	___	Auxiliary Grant
___	___	Food Stamps
___	___	Fuel Assistance
___	___	General Relief
___	___	State and Local Hospitalization
___	___	Subsidized Housing
___	___	Tax Relief

What types of health insurance do you have?

No 0	Yes 1	
___	___	Medicare, # _____
___	___	Medicaid, # _____
		Pending ☐ No 0 ☐ Yes 1
		QMB/SLMB ☐ No 0 ☐ Yes 1
___	___	All Other Public/Private _____

CLIENT NAME:	Client SSN: - -

Physical Environment

Where do you usually live? Does anyone live with you?

	Alone 1	Spouse 2	Other 3	Names of Persons in Household
___ House Own 0				
___ House Rent 1				
___ House Other 2				
___ Apartment 3				
___ Rented Room 4				

	Name of Provider (Place)	Admission Date	Provider Number (If Applicable)
___ Adult Care Residence 50			
___ Adult Foster 60			
___ Nursing Facility 70			
___ Mental Health/ Retardation Facility 80			
___ Other 90			

Where you usually live, are there any problems?

No 0	Yes 1	*Check All Problems That Apply*
___	___	Barriers to Access
___	___	Electrical Hazards
___	___	Fire Hazards/No Smoke Alarm
___	___	Insufficient Heat/Air Conditioning
___	___	Insufficient Hot Water/Water
___	___	Lack of/Poor Toilet Facilities (Inside/Outside)
___	___	Lack of/Defective Stove, Refrigerator, Freezer
___	___	Lack of/Defective Washer/Dryer
___	___	Lack of/Poor Bathing Facilities
___	___	Structural Problems
___	___	Telephone Not Accessible
___	___	Unsafe Neighborhood
___	___	Unsafe/Poor Lighting
___	___	Unsanitary Conditions
___	___	Other: _____

Describe Problems:

CLIENT NAME: Client SSN: - -

2 FUNCTIONAL STATUS (Check only one block for each level of functioning)

ADLS	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help D		MH & HH 3 D		Performed by Others 40 D			Is Not Performed 50 D
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2				
Bathing											
Dressing											
Toileting											
Transferring											
								Spoon Fed 1	Syringe/ Tube Fed 2	Fed by IV 3	
Eating/Feeding											

Continence	Needs Help?		Incontinent Less than weekly 1	External Device/ Indwelling/ Ostomy Self care 2	Incontinent D Weekly or more 3	External Device D Not self care 4	Indwelling Catheter D Not self care 5	Ostomy D Not self care 6
	No 00	Yes						
Bowel								
Bladder								

Comments:

Ambulation	Needs Help?		MH Only 10 Mechanical Help	HH Only 2 Human Help D		MH & HH 3 D		Performed by Others 40 D	Is Not Performed 50 D
	No 00	Yes		Supervision 1	Physical Assistance 2	Supervision 1	Physical Assistance 2		
Walking									
Wheeling									
Stairclimbing									
								Confined Moves About	Confined Does Not Move About
Mobility									

IADLS	Needs Help?	
	No 0	D Yes 1
Meal Preparation		
Housekeeping		
Laundry		
Money Management		
Transportation		
Shopping		
Using Phone		
Home Maintenance		

Comments:

Outcome: Is this a short assessment?

___ No, Continue with Section ◆ 0 ___ Yes, Service Referrals 1 ___ Yes, No Service Referrals 2

Screener: _____ Agency: _____

CLIENT NAME:	Client SSN: - -

3 PHYSICAL HEALTH ASSESSMENT

Professional Visits/Medical Admissions

Doctor's Name(s) *(List all)*	Phone	Date of Last Visit	Reason for Last Visit

Admissions: In the past 12 months, have you been admitted to a . . . for medical or rehabilitation reasons?

No 0	Yes 1		Name of Place	Admit Date	Length of Stay/Reason
		Hospital			
		Nursing Facility			
		Adult Care Residence			

Do you have any advanced directives such as . . . (Who has it . . . Where is it . . .)?

No 0	Yes 1		*Location*
___	___	Living Will,	
___	___	Durable Power of Attorney for Health Care,	
___	___	Other,	

Diagnoses & Medication Profile

Do you have any current medical problems, or a known or suspected diagnosis of mental retardation or related conditions, such as . . . (Refer to the list of diagnoses)?

Current Diagnoses	Date of Onset

Enter Codes for 3 Major, Active Diagnoses: ____ None 00 ____ DX1 ____ DX2 ____ DX3

	Current Medications (Include Over-the-Counter)	Dose, Frequency, Route	Reason(s) Prescribed
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8			
9			
10.			

Total No. of Medications: ____ (If 0, skip to Sensory Function) **Total No. of Tranquilizer/Psychotropic Drugs:** ____

Do you have any problems with medicine(s) . . . ?

No 0	Yes 1	
___	___	Adverse reactions/allergies
___	___	Cost of medication
___	___	Getting to the pharmacy
___	___	Taking them as instructed/prescribed
___	___	Understanding directions/schedule

How do you take your medicine(s)?

- ___ Without assistance 0
- ___ Administered/monitored by lay person 1
- ___ Administered/monitored by professional nursing staff 2

Describe help ____

Name of helper ____

Diagnoses:

- **Alcoholism/Substance Abuse (01)**
- **Blood-Related Problems (02)**
- **Cancer (03)**
- **Cardiovascular Problems**
  - Circulation (04)
  - Heart Trouble (05)
  - High Blood Pressure (06)
  - Other Cardiovascular Problems (07)
- **Dementia**
  - Alzheimer's (08)
  - Non-Alzheimer's (09)
- **Developmental Disabilities**
  - Mental Retardation (10)
  - Related Conditions
    - Autism (11)
    - Cerebral Palsy (12)
    - Epilepsy (13)
    - Friedreich's Ataxia (14)
    - Multiple Sclerosis (15)
    - Muscular Dystrophy (16)
    - Spina Bifida (17)
- **Digestive/Liver/Gall Bladder (18)**
- **Endocrine (Gland) Problems**
  - Diabetes (19)
  - Other Endocrine Problems (20)
- **Eye Disorders (21)**
- **Immune System Disorders (22)**
- **Muscular/Skeletal**
  - Arthritis/Rheumatoid Arthritis (23)
  - Osteoporosis (24)
  - Other Muscular/Skeletal Problems (25)
- **Neurological Problems**
  - Brain Trauma/Injury (26)
  - Spinal Cord Injury (27)
  - Stroke (28)
  - Other Neurological Problems (29)
- **Psychiatric Problems**
  - Anxiety Disorders (30)
  - Bipolar (31)
  - Major Depression (32)
  - Personality Disorder (33)
  - Schizophrenia (34)
  - Other Psychiatric Problems (35)
- **Respiratory Problems**
  - Black Lung (36)
  - COPD (37)
  - Pneumonia (38)
  - Other Respiratory Problems (39)
- **Urinary/Reproductive Problems**
  - Renal Failure (40)
  - Other Urinary/Reproductive Problems (41)
- **All Other Problems (42)**

CLIENT NAME:	Client SSN: - -

Sensory Functions

How is your vision, hearing, and speech?

	No Impairment 0	Impairment Record Date of Onset/Type of Impairment		Complete Loss 3	Date of Last Exam
		Compensation 1	No Compensation 2		
Vision					
Hearing					
Speech					

Physical Status

Joint Motion: How is your ability to move your arms, fingers and legs?

___ Within normal limits or instability corrected 0
___ Limited motion 1
___ Instability uncorrected or immobile 2

Have you ever broken or dislocated any bones . . . Ever had an amputation or lost any limbs . . . Lost voluntary movement of any part of your body?

Fractures/Dislocations	Missing Limbs	Paralysis/Paresis
___ None 000	___ None 000	___ None 000
___ Hip Fracture 1	___ Finger(s)/Toe(s) 1	___ Partial 1
___ Other Broken Bone(s) 2	___ Arm(s) 2	___ Total 2
___ Dislocation(s) 3	___ Leg(s) 3	Describe: _____
___ Combination 4	___ Combination 4	_____
Previous Rehab Program?	**Previous Rehab Program?**	**Previous Rehab Program?**
___ No/Not Completed 1	___ No/Not Completed 1	___ No/Not Completed 1
___ Yes 2	___ Yes 2	___ Yes 2
Date of Fracture/Dislocation?	**Date of Amputation?**	**Onset of Paralysis?**
___ 1 Year or Less 1	___ 1 Year or Less 1	___ 1 Year or Less 1
___ More than 1 Year 2	___ More than 1 Year 2	___ More than 1 Year 2

Nutrition

Height: _____ (inches) **Weight:** _____ (lbs.) **Recent Weight Gain/Loss:** ___ **No** 0 ___ **Yes** 1

Describe: _____

Are you on any special diet(s) for medical reasons?

___ None 0
___ Low Fat/Cholesterol 1
___ No/Low Salt 2
___ No/Low Sugar 3
___ Combination/Other 4

Do you take dietary supplements?

___ None 0
___ Occasionally 1
___ Daily, Not Primary Source 2
___ Daily, Primary Source 3
___ Daily, Sole Source 4

Do you have any problems that make it hard to eat?

No 0	Yes 1	
___	___	Food Allergies
___	___	Inadequate Food/Fluid Intake
___	___	Nausea/Vomiting/Diarrhea
___	___	Problems Eating Certain Foods
___	___	Problems Following Special Diets
___	___	Problems Swallowing
___	___	Taste Problems
___	___	Tooth or Mouth Problems
___	___	Other: _____

CLIENT NAME: Client SSN: - -

Current Medical Services

Rehabilitation Therapies: Do you get any therapy prescribed by a doctor, such as . . . ?

No 0	Yes 1		Frequency
___	___	Occupational	
___	___	Physical	
___	___	Reality/Remotivation	
___	___	Respiratory	
___	___	Speech	
___	___	Other	

Do you have any pressure ulcers?

		Location/Size
___	None 0	
___	Stage I 1	
___	Stage II 2	
___	Stage III 3	
___	Stage IV 4	

Special Medical Procedures: Do you receive any special nursing care, such as . . . ?

No 0	Yes 1		Site, Type, Frequency
___	___	Bowel/Bladder Training	
___	___	Dialysis	
___	___	Dressing/Wound Care	
___	___	Eyecare	
___	___	Glucose/Blood Sugar	
___	___	Injections/IV Therapy	
___	___	Oxygen	
___	___	Radiation/Chemotherapy	
___	___	Restraints (Physical/Chemical)	
___	___	ROM Exercise	
___	___	Trach Care/Suctioning	
___	___	Ventilator	
___	___	Other:	

Medical/Nursing Needs

Based on client's overall condition, assessor should evaluate medical and/or nursing needs.

Are there ongoing medical/nursing needs? ___ No 0 ___ Yes 1

If yes, describe ongoing medical/nursing needs:

1. Evidence of medical instability.
2. Need for observation/assessment to prevent destabilization.
3. Complexity created by multiple medical conditions.
4. Why client's condition requires a physician, RN, or trained nurse's aide to oversee care on a daily basis.

Comments:

Optional: Physician's Signature: _____ Date: _____

Others: _____ Date: _____
(Signature/Title)

CLIENT NAME: Client SSN: - -

4 PSYCHO-SOCIAL ASSESSMENT

Cognitive Function

Orientation *(Note: Information in italics is optional and can be used to give a MMSE Score in the box to the right.)*

Person: **Please tell me your full name** (so that I can make sure our record is correct).

Place: **Where are we now** *(state, county, town, street/route number, street name/box number)?* *Give the client 1 point for each correct response.*

Time: **Would you tell me the date today** *(year, season, date, day, month)?*

___ Oriented 0

___ Disoriented - Some spheres, some of the time 1

___ Disoriented - Some spheres, all the time 2

___ Disoriented - All spheres, some of the time 3

___ Disoriented - All spheres, all of the time 4

___ Comatose 5

Spheres affected: _____

_____

Optional: **MMSE Score**

_____ (5)

_____ (5)

_____ (3)

_____ (5)

Total: _____

Note: Score of 14 or below implies cognitive impairment

Recall/Memory/Judgement

Recall: **I am going to say three words, and I want you to repeat them after I am done** (House, Bus, Dog). ✪ Ask the client to repeat them. *Give the client 1 point for each correct response on the first trial.* ✪ Repeat up to 6 trials until client can name all 3 words. Tell the client to hold them in his mind because you will ask him again in a minute or so what they are.

Attention/ Concentration: *Spell the word "WORLD". Then ask the client to spell it backwards. Give 1 point for each correctly placed letter (DLROW).*

Short-Term: ✪ Ask the client to recall the 3 words he was to remember.

Long-Term: **When were you born** (What is your date of birth)?

Judgement: **If you needed help at night, what would you do?**

No 0	Yes 1	
___	___	Short -Term Memory Loss?
___	___	Long-Term Memory Loss?
___	___	Judgement Problem?

Behavior Pattern

Does the client ever wander without purpose (trespass, get lost, go into traffic, etc.) **or become agitated and abusive?**

___ Appropriate 0

___ Wandering/Passive - Less than weekly 1

___ Wandering/Passive - Weekly or more 2

___ Abusive/Aggressive/Disruptive - Less than weekly 3

___ Abusive/Aggressive/Disruptive - Weekly or more 4

___ Comatose 5

Type of inappropriate behavior: _____ Source of Information: _____

Life Stressors

Are there any stressful events that currently affect your life, such as . . . ?

No 0	Yes 1		No 0	Yes 1		No 0	Yes 1	
___	___	Change in work/employment	___	___	Financial problems	___	___	Victim of a crime
___	___	Death of someone close	___	___	Major illness - family/friend	___	___	Failing health
___	___	Family conflict	___	___	Recent move/relocation	___	___	Other: _____

CLIENT NAME:	Client SSN: - -

Emotional Status

In the past month, how often did you . . . ?	Rarely/ Never 0	Some of the Time 1	Often 2	Most of the Time 3	Unable to Assess 9
Feel anxious or worry constantly about things?					
Feel irritable, have crying spells or get upset over little things?					
Feel alone and that you didn't have anyone to talk to?					
Feel like you didn't want to be around other people?					
Feel afraid that something bad was going to happen to you and/or feel that others were trying to take things from you or trying to harm you?					
Feel sad or hopeless?					
Feel that life is not worth living . . . or think of taking your life?					
See or hear things that other people did not see or hear?					
Believe that you have special powers that others do not have?					
Have problems falling or staying asleep?					
Have problems with your appetite . . . that is, eat too much or too little?					

Comments:

Social Status

Are there some things that you do that you especially enjoy?

No 0	Yes 1		*Describe*
___	___	Solitary Activities,	_____
___	___	With Friends/Family,	_____
___	___	With Groups/Clubs,	_____
___	___	Religious Activities,	_____

How often do you talk with your children, family or friends, either during a visit or over the phone?

Children

- ___ No Children 0
- ___ Daily 1
- ___ Weekly 2
- ___ Monthly 3
- ___ Less than Monthly 4
- ___ Never 5

Other Family

- ___ No Other Family 0
- ___ Daily 1
- ___ Weekly 2
- ___ Monthly 3
- ___ Less than Monthly 4
- ___ Never 5

Friends/Neighbors

- ___ No Friends/Neighbors 0
- ___ Daily 1
- ___ Weekly 2
- ___ Monthly 3
- ___ Less than Monthly 4
- ___ Never 5

Are you satisfied with how often you see or hear from your children, other family and/or friends?

___ **No** 0 ___ **Yes** 1

CLIENT NAME:	Client SSN: - -

Hospitalization/Alcohol - Drug Use

Have you been hospitalized or received inpatient/outpatient treatment in the last 2 years for nerves, emotional/mental health, alcohol or substance abuse problems?

___ No 0 ___ Yes 1

Name of Place	Admit Date	Length of Stay/Reason

Do (did) you ever drink alcoholic beverages?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Do (did) you ever use non-prescription, mood altering substances?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

If the client has never used alcohol or other non-perscription, mood altering substances, skip to the tobacco question.

Have you, or someone close to you, ever been concerned about your use of alcohol/other mood altering substances?

___ No 0 ___ Yes 1

Describe concerns: _____

Do (did) you ever use alcohol/other mood-altering substances with...

No 0 Yes 1

___ ___ Prescription drugs?
___ ___ OTC medicine?
___ ___ Other substances?

Describe what and how often:

Do (did) you ever use alcohol/other mood-altering substances to help you...

No 0 Yes 1

___ ___ Sleep?
___ ___ Relax?
___ ___ Get more energy?
___ ___ Relieve worries?
___ ___ Relieve physical pain?

Describe what and how often:

Do (did) you ever smoke or use tobacco products?

___ Never 0
___ At one time, but no longer 1
___ Currently 2
How much: _____
How often: _____

Is there anything we have not talked about that you would like to discuss?

CLIENT NAME:	Client SSN: - -

5 ASSESSMENT SUMMARY

Indicators of Adult Abuse and Neglect: *While completing the assessment, if you suspect abuse, neglect or exploitation, you are required by Virginia law, Section 63.1 - 55.3 to report this to the local Department of Social Services, Adult Protective Services.*

Caregiver Assessment

Does the client have an informal caregiver?

___ **No** 0 (Skip to Section on Preferences) ___ **Yes** 1

Where does the caregiver live?

___ With client 0
___ Separate residence, close proximity 1
___ Separate residence, over 1 hour away 2

Is the caregiver's help . . .

___ Adequate to meet the client's needs? 0
___ Not adequate to meet the client's needs? 1

Has providing care to the client become a burden for the caregiver?

___ Not at all 0
___ Somewhat 1
___ Very much 2

Describe any problems with continued caregiving:

Preferences

Client's preferences for receiving needed care: _____

_____

_____

Family/Representative's preferences for client's care: _____

_____

_____

Physician's comments (if applicable): _____

_____

_____

CLIENT NAME:	Client SSN: - -

Client Case Summary

Unmet Needs

No 0	Yes 1	(Check All That Apply)
___	___	Finances
___	___	Home/Physical Environment
___	___	ADLS
___	___	IADLS

No 0	Yes 1	(Check All That Apply)
___	___	Assistive Devices/Medical Equipment
___	___	Medical Care/Health
___	___	Nutrition
___	___	Cognitive/Emotional
___	___	Caregiver Support

Assessment Completed By:

Assessor's Name	Signature	Agency/Provider Name	Provider#	Section(s) Completed

Optional: Case assigned to: _____ Code #: _____